NEW YORK STATE DEPARTMENT OF HEALTH
HIV UNINSURED CARE PROGRAMS

DATE RECEIVED BY PROGRAM: _____

AIDS DRUG ASSISTANCE PROGRAM (ADAP)
ADAP PLUS (PRIMARY CARE)
HIV HOME CARE PROGRAM
ADAP PLUS INSURANCE CONTINUATION (APIC)

MEDICAL ELIGIBILITY FORM
SU MEDICO NECESITA ESTA FORMA

This form must be completed by the attending physician. The information will be used to determine your patient's eligibility to receive assistance through the Programs, which are federally funded programs administered by the New York State Department of Health. Please note that the disclosure of HIV information should occur with the signed written consent of the patient.

MEDICAL ELIGIBILITY: AIDS Drug Assistance Program and/or ADAP Plus = **HIV+**

Home Care = HIV Illness and Medically or Chronically Dependent due to HIV Illness

(PLEASE ATTACH TREATMENT PLAN FORMS: AI 485, AI 487, AI 3615 and Nursing Assessment)

1.) PATIENT INFORMATION (Please print or type)

Name _____
(Last) (First) (M.I.)

Address _____
(c/o) (Street) (Apt. #)

City _____ State New York Zip Code _____

Date of Birth ____/____/____

Telephone (_____) _____ (_____) _____
(Home) (Work) (ext.)

2.) PHYSICIAN INFORMATION and VERIFICATION (Please print or type) DEA # _____

Name _____ NYS License # _____

Hospital or Facility _____ Medicaid # _____

Address _____

City _____ State _____ Zip Code _____

Office Telephone Number (_____) _____ ext. _____

Alternate Contact for
Medical Follow Up _____
(Name) (Telephone #)

Physician Verification:
I verify that the information on this application is true to the best of my knowledge.

Physician Signature: _____ _____
(MUST BE ACTUAL SIGNATURE) **(DATE)**

ON THE BACK OF THIS FORM, PLEASE PROVIDE THE INFORMATION REQUESTED. IF YOU HAVE ANY QUESTIONS ABOUT MEDICAL ELIGIBILITY PLEASE CONTACT OUR TOLL FREE HOTLINE **1-800-542-2437**. WHEN COMPLETED PLEASE RETURN TO:

EMPIRE STATION
P.O. BOX 2052
ALBANY, NEW YORK 12220-0052

MEDICAL INFORMATION
Please Answer All Questions

APPLICANTS NAME: _____

SECTION I - DISEASE STAGING

1.) Is the applicant HIV infected? [ ] Yes [ ] No Year of First Positive Test

2.) What is this applicant's most recent CD4+ (T_4) count? _____/mm^3 **Date of Test:** _____/_____/_____

3.) What is lowest CD4+ (T_4) count? _____/mm^3 **Date of Test:** _____/_____/_____

4.) Lymphocyte % = _____% **Date of Test:** _____/_____/_____

5.) Viral Load _____ **Date of Test:** _____/_____/_____

PLEASE ENCLOSE A COPY OF THE LAB (CD4+ or viral load) REPORT

6.) Does the applicant have CDC-defined AIDS? [ ] Yes [ ] No **Date of Diagnosis**: _____/_____/_____

Location at time of AIDS diagnosis (State and County): _____

7.) Does the applicant have Clinical/Symptomatic HIV Illness (includes CDC-Defined AIDS and HIV related disease)? [ ] Yes [ ] No

SECTION II - DISEASE HISTORY

1.) Does the applicant now have or ever had:

[ ] Malignancies [ ] AIDS Dementia/PML [ ] Mycobacterium Avium Complex
[ ] Wasting Syndrome [ ] Syphilis [ ] PCP

2.) Tuberculosis - No Evidence of TB [ ]

Evidence of TB **and:**

[ ] Active, receiving treatment
[ ] Active, no treatment
[ ] Active, treatment unknown

or

Evidence of TB **but**:

[ ] Inactive, prophylaxis
[ ] Inactive, no prophylaxis
[ ] Inactive, treated

3.) Risk Behavior (check all that apply):

[ ] IVDU
[ ] Transfusion/Blood Product
[ ] Sexual Abuse/Assault
[ ] Health Care Setting
[ ] Maternal

Sex with:

[ ] IVDU [ ] Other
[ ] Male [ ] Unknown
[ ] Female
[ ] Person with HIV/AIDS

SECTION III - TREATMENT HISTORY

1.) Has a comprehensive HIV evaluation been conducted? [ ] Yes [ ] No

2.) Has anti-retroviral treatment been recommended? [ ] Yes [ ] No

3.) Has PCP prophylaxis been recommended? [ ] Yes [ ] No

4.) Has the applicant had these immunizations:
Influenza [ ] Yes [ ] No
Hepatitis B Vaccine [ ] Yes [ ] No
Pneumovax [ ] Yes [ ] No

5.) Is the applicant participating in clinical trials for anti-retroviral or secondary infections treatment? [ ] Yes [ ] No

6.) Does the applicant currently require Home Care? [ ] Yes [ ] No

7.) PPD Status: [ ] Positive [ ] Anergic [ ] Negative [ ] Unknown